NHSProviders

Briefing

22 October 2020

WORKFORCE FLEXIBILITY IN THE NHS

Utilising COVID-19 innovations

Background

The outbreak of COVID-19 has presented one of the biggest challenges which the NHS has ever faced, against a backdrop of sustained underfunding and growing workforce pressures. Responding to the pandemic has placed new and drastically increased demands on services, equipment, and staff. To meet these demands, innovations and change were brought about in the NHS at a rapid pace during the initial peak of the pandemic.

The NHS is currently facing a second wave of the virus, with high infection rates likely to persist alongside winter pressures in the coming months. It is crucial the service acts now to implement learning from the first peak. Capturing changes which have been advantageous, analysing them, and properly implementing those which will bring about longer-term benefits is key to the NHS coping with further waves, and recovering from the effects of the pandemic and resulting service backlog. This importance has been recognised and acted upon by key stakeholders, particularly NHS England and NHS Improvement's Beneficial Changes Network and in the NHS People Plan 2020/21. There is appetite across the board to implement learning and codify positive disruptions from the pandemic, and trust leaders are supportive of this.

This briefing focuses specifically on NHS workforce flexibilities and innovations. It has been directly informed by trust leaders, drawn from the conclusions of a roundtable discussion held in July, which focused on changes to workforce management during the first peak of COVID-19 in England. This briefing explores and makes recommendations on six key areas of change:

1. staff wellbeing
2. flexibility in staff deployment and roles
3. cross-organisational working and regulation
4. technology
5. making use of new roles
6. funding.

Key points

- The speed at which workforce innovations and flexibilities have been implemented in the NHS since the outbreak of COVID-19 has been both impressive and encouraging. These changes should be codified into policy and practice, to ensure that valuable improvements secured in the first peak of COVID-19 are not lost.
- The dedication of NHS staff throughout the pandemic has been outstanding. However, there is significant concern of staff burnout, with NHS Providers' survey finding that 99% of trust leaders are either extremely or moderately concerned about the current level of burnout across the workforce – particularly as the NHS enters a second peak alongside winter pressures.
- COVID-19 has brought into sharp relief the health risks of long-standing race inequalities. National and local initiatives to address racial inequality in the NHS must empower and protect Black, Asian, and minority ethnic (BAME) people, without prescribing "one size fits all" solutions or putting the onus of change upon BAME staff.
- Local wellbeing initiatives need appropriate central funding to continue, so that trusts are not forced to choose between staff wellbeing and investing resources in frontline care. In the longer term, the central focus of wellbeing initiatives must be to build flexibility and support into the system, rather than to focus disproportionately on the resilience of individual members of staff.
- Reduced bureaucracy in staff deployment across the NHS has increased opportunities for staff to work flexibly, and to develop skills in new areas. These opportunities should be retained, but questions of liability and patient experience must be answered.
- The contributions of fast-tracked students, and the return of staff who had previously left the NHS, valuably increased workforce capacity. There are ways to continue to engage these staff in the NHS, but this will require funding and expanded training locations. The regulation of Medical Associate Professionals (MAPs) should also be prioritised to enable fuller use of these roles.
- Increased collaboration across the health and care system, alongside simplified regulation, has been enormously beneficial to the delivery of care during the pandemic. This should be retained and strengthened.
- The expansion of virtual consultations and remote care has greatly increased NHS capacity, but retaining the flexibility to offer and conduct face to face care is of key importance to trusts.
- Ensuring software interoperability across the NHS is a matter of urgent priority, and funding for home-working equipment must be made available to retain this as a viable option for NHS staff.
- Funding to ensure the recruitment and retention of NHS staff has never been more vital.

1 Workforce flexibility and innovation during COVID-19

Prior to the pandemic, NHS trusts were already grappling with rapidly growing demand for healthcare. The NHS was facing its longest and deepest financial squeeze in history with over 100,000 workforce vacancies in the trust sector alone, and staff exhausted after coping with year-round levels of 'winter' demand. It is within this context that the NHS created sufficient extra capacity, at great speed, to successfully manage demand for COVID-related treatment within the first peak of the virus, while also maintaining urgent and emergency care and other critical services.

Workforce innovations were one category of a broader tranche of changes which trusts made to enable this, and trusts have particularly emphasised it as crucial in the service's COVID-19 response. Key workforce innovations which trust leaders have told us were particularly helpful are explored below, with recommendations as to how they can be given longevity to bring about a more flexible approach to workforce management in the NHS. This will help to enable delivery of care in a way which benefits NHS staff, trust leaders, and patients, capitalising on the innovations brought about by exceptional circumstances. It is vital that this is codified to avoid the re-ossification into previously established approaches, as the NHS returns to large scale non-COVID service delivery and faces further waves of the virus.

Staff wellbeing

To protect the wellbeing of the NHS workforce in the long term, enough additional staff are needed not only to cover existing workforce gaps, but also to build flexibility into the system. Wellbeing is often spoken of at an individual staff level, but by building a resilient system, workforce wellbeing will be far better protected by realistic workloads, more regular and reliable breaks, and better work life balance. In discussion with the Healthcare Safety Investigation Branch (HSIB), we have heard their own opinion that, based on safety science research, patient safety in the NHS would also be enhanced most effectively by looking at organisational resilience.

However, the NHS is currently far from this ideal. The 2019 NHS Staff Survey, conducted before the COVID-19 outbreak, showed that too many staff are stretched beyond a reasonable limit. Only 22.9% of respondents said they "never" or "rarely" experienced unrealistic time pressures in their jobs, and just 32.3% said there were enough staff in their organisation to allow them to do their job. Initiatives such as the Interim NHS People Plan are working towards building flexibility into the system, but this work is very much still ongoing.

Protecting staff wellbeing has never been more vital than during the initial peak of the COVID-19 outbreak, in which staff worked harder than ever. Trusts have repeatedly told us that the good will and commitment from the NHS workforce during the pandemic has been outstanding. The incredible response from staff to meet the demands placed on them throughout the first peak and beyond has been a key point of success and pride for trust leaders, who are keenly aware of enormous efforts that the pandemic has taken from the NHS workforce, and that their wellbeing is consequently at risk.

COVID-19 has brought into sharp relief the health risks associated with long-standing race inequalities. The disproportionate effect of the virus on BAME people, including those working in health and care settings, quickly became clear during the outbreak's initial peak. In response, NHS leaders and staff have sought to understand the actions that can be taken to address these issues within their organisations, not only in the face of COVID-19, but with the ultimate aim of confronting structural racism within the NHS. Trust leaders have put processes in place to better enable uncomfortable and challenging conversations on racial equalities issues and create a sense of psychological safety for staff to give frank and honest reflections on experiences of racism within the NHS. Many trusts have been running enhanced staff engagement and listening events to ensure that concerns from their workforce are heard, and action is taken in response. These events have been helped by work within trusts to ensure a stronger voice for BAME networks , many of which have helped boards to promote the importance of allyship and anti-racist activism so that BAME staff and networks are not called on to do the 'heavy lifting' in creating change.

In direct response to the disproportionate effect of COVID-19 on BAME people, trusts began to carry out risk assessments and make arrangements to protect at-risk staff. With support from NHS England and NHS Improvement, trusts found this a useful first step to reaching individualised solutions, which had to be tailored to meet each staff member's needs and preferences. While redeployment was necessary in some cases, guidance from national bodies helped trusts to identify levels of risk, without prescribing a "one size fits all" outcome for all BAME staff. Prerana Issar, NHS England and NHS Improvement chief people officer, announced at NHS Providers' annual conference and exhibition that as of 8 October 2020, 96% of BAME staff had engaged in an individual risk assessment. These processes have set the foundations for more engagement on health and wellbeing issues between staff and their managers. This work is of vital importance, and must be adopted as default, long-term approach to workforce management across the NHS.

Trusts are conscious of the impact on NHS staff wellbeing which has been brought about by personal risk of infection when caring for COVID-19 positive patients, alongside the possibility of bringing infection home to loved ones, and the trauma of caring for a huge influx of critically ill patients. This is all set against the context, highlighted by the 2019 NHS Staff Survey, that an unsustainable level of discretionary additional effort was being given by staff even before the pandemic hit. NHS Providers conducted a survey of trust chairs and executive directors in August, which found particular concern about the resilience and wellbeing of staff after the first wave, with 99% of respondents either extremely or moderately concerned about the current level of burnout across the workforce. In July, via a joint statement with the Academy of Medical Royal Colleges, the British Medical Association, NHS Confederation, the Royal College of Nursing and UNISON, NHS Providers called for "active national support through a sustained and coordinated approach to mental health and wellbeing is essential for the recovery period if staff are to be retained and remain engaged". The NHS People Plan 2020/21, also published in July, recognised these concerns and has dedicated a chapter to "looking after our people".

While the People Plan 2020/21 offers a coordinated national approach to the physical health and wellbeing of staff – for example through infection control prevention measures, personal protective equipment (PPE) systems, flu vaccination programmes, and risk assessments – the same is lacking for mental wellbeing. The reliance remains for organisations to take local action on this front, with the mandated appointment of a wellbeing guardian as the only national change. We have seen an increase in such local action since February; for instance, wellbeing hubs (promoting access to information and resources) and wellbeing rooms (which staff can use to take time out of stressful days and recuperate) have been set up in many trusts and are functioning well. However, such action needs steady funding to continue longer term, to address the issues of staff wellbeing that were prevalent prior to the pandemic, and to ensure the inclusion of pastoral care staff and post-traumatic stress disorder support (vital to wellbeing during the pandemic in particular) via access to mental and occupational health services. Trust leaders have told us that access to clinical psychologist support for teams has been particularly difficult to come by. While there has been some access for senior managers nationally, the feeling is that the support should be prioritised for frontline workers. Central funding and coordinated access to specialist resource would enable this.

Trusts have also highlighted to us the importance of having softer flexibilities to support staff wellbeing built into workforce management processes, such as free meals and hot drinks. An example of a national approach to these flexibilities is the Department of Health and Social Care's financial backing for all trusts to provide free car parking for staff for the duration of the pandemic. This has been of huge benefit to staff wellbeing, and for free parking to remain in place, it will be vital for trusts to receive sufficient funding to pay for it to enable them to maintain their premises and not divert funding from frontline services. The funding for car parking is yet to cease at the time of writing this briefing, and NHS Providers will keep highlighting that the government should commit to continuing to pay for this beyond COVID-19, along with funding for other softer flexibilities and support.

Finally, it is worth noting that donations and wider public support (such as clapping on Thursdays, and supportive signs in windows) to appreciate staff during the pandemic have been well-received and helped with morale. However, work must be done to translate these gestures into longer-term, tangible outcomes. We believe that there is potential for a new conversation with the public – and their representatives in public office – around demand and how NHS services are used and funded. Increasing early intervention and preventative measures among the population to reduce service demand will be beneficial long-term and will be of particular help in the event of further waves of COVID-19.

Recommendations

- The Comprehensive Spending Review must make provision for additional national funding to support the local action which has been taken to improve NHS staff wellbeing. It is vital that the funding is additional, to ensure that trusts (and other parts of the health and care system) are not forced to choose between staff wellbeing and investing resources in frontline care.

- We call again for active national support for NHS staff through a sustained and coordinated approach to mental health and wellbeing and an emphasis on building flexibility into the system, rather than solely focusing on fortifying individual staff resilience. While trust leaders will play a vital role in delivering this and any national support must be responsive to local need, we believe that the anticipated next publication of the NHS People Plan will be the best forum for this approach to be set out.
- National and local initiatives to address racial inequality in the NHS must empower and protect BAME people, without prescribing "one size fits all" solutions or putting the onus of change upon BAME staff. This work is of vital importance, and must be adopted as default, long-term approach to workforce management across the NHS.

Flexibility in staff deployment and roles

Flexibility in the scope of staff roles and deployment in the NHS have traditionally been limited. The work and responsibilities given to staff correlate closely to a specific job description within a specific area. However, greater flexibility over workforce deployment (while maintaining safety measures around competence and training) can be beneficial for staff, developing wider skillsets and increasing motivation. During the first peak of COVID-19 in England, staff movement between employing organisations and different clinical settings was made significantly more straightforward by reduced bureaucracy, such as the wider implementation of the digital NHS staff passport enabling staff to begin new posts more quickly, and avoid repeated (time-consuming) training.

There is particular support among staff for the effect of reduced bureaucracy, with the BMA's member survey in June finding that 70.38% of respondents feel that the decreased volume of paperwork and bureaucracy during the pandemic should be retained in the longer term. There will need to be ongoing learning to ensure that unintended consequences are spotted, considered, and rectified, but the reduction of bureaucracy in staff deployment is a significant and useful flexibility in workforce management.

The redeployment of specifically skilled staff in more general settings during the pandemic has brought benefits to patient care beyond filling workforce gaps. One trust has reported that physiotherapists being redeployed to wards has made discharge time for patients significantly shorter as they had early access to staff who are trained in physiotherapy. Another trust reported how a paediatric nurse was redeployed to a care home, where her skills were hugely beneficial in interacting with residents who have dementia. As part of the NHS People Plan 2020/21, Health Education England are developing plans to support local health and care systems to establish the infrastructure for 'Generalist Schools' with new training opportunities in place by August 2021, which presents a key opportunity to codify this learning and lock it in.

Retaining new training which staff have received during redeployment presents another opportunity. One trust has committed to keep redeployed staff involved in one shift per fortnight in their redeployed setting, to ensure they retain the necessary skills to respond to further waves.

Redeployment has also provoked questions about how staff are trained, there is much that can be undertaken on the job, and there are other skills which have been shown to need centralised or theoretical training. One trust has stated that staff were waiting weeks to complete an online training module before being redeployed, when they could have been taught more efficiently through hands on experience. Empowering trusts to have greater discretion over delivery of staff training in this regard would accelerate staff deployment. It will be helpful for education bodies, in partnership with trusts, to review which training needs to be delivered online, and which can be undertaken on the job, maximising benefits from the learning gained by trusts during the first peak of the pandemic.

Alongside more rapid redeployment of staff, less administrative burden, and new skills gained in the workforce, trust liability must be considered. Trusts are open to litigation if there are poor outcomes in care outside a staff member's area of defined expertise. During the peak of the outbreak, some trusts have told us that questions of liability and insurance to address this risk had to be answered anew each time a staff member was redeployed across settings. This resulted in burdensome contractual reviews and time intensive liaison with legal teams.

To streamline this process, legal infrastructure needs to be built into workforce management processes as standard, to allow for more straightforward redeployment between settings which still ensures both patient and staff safety. Trust leaders have told us that while secondment arrangements can be used to redeploy staff, they are not always ideal, as they can attract significant VAT payments where costs are recharged. This means that organisations either loan staff for free (which impacts their budgets), or the receiving organisation has to pay additional VAT. Secondment arrangements are therefore an unsatisfactory answer to the question of liability, and an unnecessary barrier to workforce flexibility in the NHS. We have heard from trust leaders that the most useful potential solution would instead be a compilation of standard principles about redeploying staff, and a memorandum of understanding (MOU) framework which covers the legalities of cross-healthcare roles. These tools would provide the blueprint for the answers to questions of liability and insurance. They could then be used by trusts as a pro-forma template, into which they could easily insert the particulars the redeployed role. Any such template needs to include clarity on practical questions, particularly around whether NHS liability insurance extends to roles in other settings, and who is liable for providing sick pay if a staff member is on sick leave redeployed.

The voluntary return of staff who had previously left the NHS was of enormous benefit to trusts during the peak of the COVID-19 outbreak in England and contributed to the creation of much needed additional capacity. However, there was a relatively low level of deployment of the overall number of people who volunteered to return to work during the peak of the pandemic. This was due to several issues, including problems with the matching process between the national/regional NHS England and NHS Improvement teams and trusts, some returners being unwilling to work in frontline roles, and some trusts not needing returners because substantive staff had been redeployed from paused or reduced services. Further operational planning across the NHS is therefore required to maximise the potential benefit of returners ahead of further waves of the virus.

Despite slow initial deployment, NHS England and NHS Improvement's BBS returner survey in May found that over 50% of those who returned to work in the NHS (from retirement or from outside the NHS) during the peak of the pandemic are 'interested in continuing to work in the health and social care system in the medium to long term in some capacity'. Attention has already been given as to how these returners can be kept on longer term, to aid workforce planning. In discussion with the General Medical Council, we have heard that initial suggestions for the formation of a staff reserve are no longer viable, instead, trusts and systems will be encouraged to make offers of employment to returners. This would create a predictable resource to bolster the workforce but is not possible without necessary additional funding to take returners on as permanent staff members. As the backlog of care begins to be addressed, funding to enable these employment offers will be particularly helpful, and returners will be able to be deployed in greater numbers as they are incorporated into normal workforce planning processes.

Alongside the benefits of flexible staff deployment, both to staff and to service delivery, HSIB have flagged that potential risks of staff fatigue, burnout and impaired performance must be clearly understood and mitigated. As such, assessment of any changes to patient experience from redeployment and returners will be vital moving forwards. HSIB have also suggested taking actions, and communicating with staff effectively, to protect against particular risk factors including but not limited to unfamiliar working conditions, escalation pathways, and changing guidance in different roles. An ongoing approach that supports trusts to assess and respond to any arising risks will be vital to gain a better understanding, stay alert for unintended consequences, and embed changes in a way which will be beneficial to the delivery of care in the NHS longer term.

Recommendations

- The Department of Health and Social Care must work closely with trust and system leaders to create a highly supportive environment with appropriate additional funding, to ensure the retention of COVID returners. Offers of employment for returners should be based on their stated preferences regarding location and type of work, as well as their training and expertise.
- Reduced levels of bureaucracy around staff deployment should be retained, with increased roll out of the NHS staff passport (subject to recommendation eight). The recommendations which arise from HEE and NHS England and NHS Improvement's streamlining programme should be considered, in terms of reducing duplicative administration processes.
- NHS England and NHS Improvement's guidance on safe and legal deployment should be developed into a national MOU framework and a set of principles about redeploying staff, as detailed above. This will support workforce management processes and allow for more straightforward redeployment, rather than questions of liability needing to be answered anew each time.

Cross-organisational working and regulation

COVID-19 has accelerated collaboration across the health and care system, helping to meet unprecedented levels of demand. As a result, collaboration across organisations and teams has improved, particularly in areas where the foundations of system working and integration had already been laid. Examples from trust leaders include: staff from community healthcare trusts who were redeployed to care homes with staff shortages to prevent them from having to close; and certain clinical teams switching from hospital-based to out of hospital models of care. Some sustainability and transformation plans (STPs) and integrated care systems (ICSs) also created system-wide staff banks, enabling workforce gaps to be filled more efficiently.

The NHS People Plan 2020/21 makes reference to the fact that STPs and ICSs will be expected to support cross-organisational working going forwards, and sets an initial action on this front in the requirement of local people plans to be developed. This indicates a move towards recruitment and workforce planning based on systems rather than organisations, which would build on trusts' pre-existing use of system working to collaborate. The pandemic has shown that joined up recruitment and workforce planning is a possible and useful alternative to previously established recruitment practices aimed at a limited pool of staff. NHS Providers supports this approach.

A more streamlined regulatory environment during the pandemic has facilitated rapid action and decision-making between different health and care organisations. The scaling back of input from national bodies has been helpful for trusts in delivering COVID-19 care at pace – particularly with greater flexibility around staffing ratios. There is real opportunity for future regulation to be built on learning gained from experience during the COVID-19 pandemic. While approaches such as flexibility around staffing ratios would not be suitable in "normal" post-COVID provision, NHS Providers would support adapting pandemic practice to generate a more proportionate, risk-based approach to regulation, using insight gained through other means to identify where safety risks are emerging. Such a system must account for the fact that financial pressures can derail providers from longer term strategic priorities, which risks compromising safety of both patients and staff.

Recommendations

- A more proportionate, risk-based approach to regulation should be generated, built on learning from the approach taken during the pandemic. Such an approach should enable rapid decision-making at a local level, and use insight gained through other means to identify where safety risks are emerging.

Technology

Despite the successful examples of cross-organisational working discussed in the previous section, there is still a way to go to overcome common challenges presented by cross-organisational boundaries. A particularly prevalent challenge is in organisations using different digital tools for the same purposes, and the lack of interoperability between their software. This has particularly undermined the effectiveness of digital staff passports, with some HR software programmes unable to speak to others. Work should be undertaken to identify digital solutions where a national approach to coordination would be beneficial to the entire sector – for example, the recent deal struck with Microsoft for Office 365. Beyond this, national bodies can support system integration and interoperability through the promotion of frameworks, which can guide organisations to make more informed procurement decisions.

A more positive outcome from use of technology during the pandemic has been the increase of NHS capacity through expanded use of virtual consultations and remote care. Trusts have told us that this has led to benefits for outpatient experience and enabled better prioritisation of care delivery. However, as per Healthwatch England, National Voices, Traverse, and PPL's insights report, *The Doctor will Zoom you now*, evaluation of patients outcomes is necessary and future use of virtual consultations and care must be designed around patient feedback.

In our survey of chairs and chief executives in May, all trusts reported that they will continue to deliver some non-COVID care remotely, such as via telephone or video call where appropriate. 86% of trusts have increased their capacity for remote services (i.e. video and telephone appointments). Similarly, in the BMA's June survey of hospital doctors, 73.7% of respondents feel that greater use of remote consultations should be retained in the longer term. While there is a clear preference to retain some remote services, this will vary depending on local need, staff preference and clinical suitability. For example, trusts providing community services have been clear that even if services are 'digital first', they will still be providing face to face consultations and care to those who need it. We believe that maintaining this flexibility is the correct approach.

Incorporating the needs of patients, service users, and staff (clinical and non-clinical) is key as virtual consultations and care continue to be used on a wider scale than the NHS has previously seen. The Topol Review makes several recommendations to this end, which should be considered as the NHS reviews what it should adopt, adapt and abandon during this next phase of the pandemic. It will be vital to continue guaranteeing the security of patient data, and to ensure regular maintenance of digital platforms and software alongside comprehensive staff training in using it. This will ensure that new digital ways of working are robust and compliant with existing regulations and governance.

Trust leaders have told us that use of Microsoft Teams across the NHS has enabled greater communication and collaboration between staff across different levels within organisations. It has also meant senior teams are more visible and accessible. While this is not appropriate for all environments (such as staff working on busy hospital wards) and some face to face

meetings need to be maintained, the increased use of virtual meetings has supported increased home working for NHS staff. This has been beneficial for many staff, particularly in terms of safety and work/life balance, and appropriate home working environments and equipment will be vital to sustain this offer. While there is a clear preference to retain some remote working, this will vary depending on local need and staff preference. As above, we believe that maintaining this flexibility is the correct approach.

IT spend in the NHS has traditionally come from capital budgets rather than revenue budgets. Increasingly, however, funding is shifting to subscription-based models for software licenses and services, which incur revenue charges rather than annual capital charges. Accordingly, funding for this work should be supported a blended revenue and capital model.

Recommendations

- It is vital that national steer is provided on requirements for HR software, to allow trusts to procure services safe in the knowledge that if they adhere to national requirements there will be interoperability at a local level. This should come as part of wider work on digital interoperability across system working.
- Patient outcomes from virtual consultations and remote care must be evaluated as a matter of priority, with feedback incorporated into ongoing operation of these digital platforms via co-production with patients. A national approach must then be taken to identifying what good looks like in terms of the delivery of true digital services. Revenue funding should be made available, to support this through the funding of software licenses, training and educating and other new digital support services.
- Additional capital funding should be made available to enable trusts to provide staff with necessary home working equipment, to ensure that this remains a viable option for flexible working going forwards.

Making use of new roles

To build additional capacity in the NHS workforce during the pandemic, final-year medical and nursing students were fast-tracked and given temporary registration to begin clinical work. The contribution of these students has been invaluable over the course of the COVID-19 outbreak, and we have repeatedly heard trusts praising their contributions. Trusts have also highlighted the potential advantages of additional clinical practice at this stage of students' careers. Health education institutions should therefore reconsider trainee settings, having third year students in community and mental health trusts, not just acute, was extremely helpful during the peak of the COVID-19 outbreak in England.

Another element of the NHS workforce which has previously been underutilised is professionals in 'new roles', including Medical Associate Professionals (MAPs). There have been restrictions from fully incorporating these staff members into workforce planning in the recent past, due to: perceived lack of flexibility over skills mix, inadequate access to training

and development for professionals in these roles; and significant uncertainty caused by a lack of regulation (physician associates) and incomplete professional guidance (nursing associates). Addressing these issues will allow for fuller utilisation of MAPs and thereby create additional capacity for the NHS to deliver care going forwards.

There is some discussion in the NHS People Plan 2020/21 around how the additional capacity can also be created by using the 'weaker labour market' to recruit, given that the global pandemic has led to significant job losses. However, it will be difficult for trusts to design and implement new entry level healthcare roles at this time, due to the wider pressures they are dealing with, including the backlog of demand for services. Given that NHS England and NHS Improvement have reported significant increases in NHS applications (a 17% rise in applicants to nursing-related courses, and 407,000 wider applications to the NHS submitted in March – an increase of 13,500 from March 2019), we believe that existing routes into healthcare careers should be focused on for recruitment while the pandemic is ongoing. This is particularly important given the possibility of staff attrition due to burnout following the pandemic – evidence suggests that staff will be likely to present with burnout around two and a half to seven years after experiencing trauma. As such, we believe that the focus should be on retention, as well as existing routes into healthcare careers, for the immediate future.

Recommendations

- The GMC's work on the regulation of MAPs should be prioritised to enable fuller use of these roles.
- Health education institutions should consider expanding trainee settings to more types of trust and should retain clinical placements for final year students. Mandatory training should also be reviewed with the objective of giving trusts greater discretion over what can be taught through on the job practical (rather than theoretical) learning.
- Development of new entry level healthcare roles should not be mandated of trusts until the backlog of care resulting from the COVID-19 outbreak is at a manageable level. Existing routes should continue to be recruited to instead. If new roles are created at a national level, it is vital to have a transparent national conversation on this to attain trust input before implementation.

Funding

The provision of additional government funding to cover the unforeseen costs of responding to the first wave of the coronavirus emergency (as per Sir Simon Stevens, NHS England and NHS Improvement chief executive, and Amanda Pritchard, NHS England and NHS Improvement chief operating officer's letter on 17 March) has been immensely helpful for workforce management in the NHS. Streamlined governance processes, which enabled swift budget approval, have also been key. Ensuring that this funding gets to the right areas of workforce management has been vital to embed the beneficial changes identified in this briefing, and our recommendations set out which areas we believe require this.

It must be recognised that embedding beneficial workforce changes won't save money or increase productivity immediately. Currently the NHS is experiencing waiting lists which are predicted to rise to 10 million by the end of 2020, following pre-COVID waiting lists of 4.2 million, according to a report from the NHS Confederation. While underutilisation of current staff stemming from paused services due to COVID has been a factor in this projected increase, services have now largely restarted as phase three demands have been acted upon. However, the resultant backlog of care means trusts will continue to struggle to meet targets for the foreseeable future and will require continued additional funding to do so.

Recommendations

- Calls for funding to specific areas of innovation as per this report's recommendations should be actioned. Of central importance is the retention and recruitment of NHS staff, which requires investment in wellbeing, improved technology, and greater flexibility in working patterns and roles. This will improve trusts' ability to deliver high quality care. Trusts are continually working to improve their offer to staff but are restricted in the range of improvements they can make without appropriate additional funding.

Summary of recommendations

2

Staff wellbeing

- The Comprehensive Spending Review must make provision for additional national funding to support the local action which has been taken to improve NHS staff wellbeing. It is vital that the funding is additional, to ensure that trusts (and other parts of the health and care system) are not forced to choose between staff wellbeing and investing resources in frontline care.
- We call again for active national support for NHS staff through a sustained and coordinated approach to mental health and wellbeing and an emphasis on building flexibility into the system, rather than solely focusing on fortifying individual staff resilience. While trust leaders will play a vital role in delivering this and any national support must be responsive to local need, we believe that the anticipated next publication of the NHS People Plan will be the best forum for this approach to be set out.
- National and local initiatives to address racial inequality in the NHS must empower and protect BAME people, without prescribing "one size fits all" solutions or putting the onus of change upon BAME staff. This work is of vital importance, and must be adopted as default, long-term approach to workforce management across the NHS.

Flexibility in staff deployment and roles

- The Department of Health and Social Care must work closely with trust and system leaders to create a highly supportive environment with appropriate additional funding, to ensure the retention of COVID returners. Offers of employment for returners should be based on their stated preferences regarding location and type of work, as well as their training and expertise.
- Reduced levels of bureaucracy around staff deployment should be retained, with increased roll out of the NHS staff passport (subject to recommendation eight). The recommendations which arise from HEE and NHS England and NHS Improvement's streamlining programme should be considered, in terms of reducing duplicative administration processes.
- NHS England and NHS Improvement's guidance on safe and legal deployment should be developed into a national MOU framework and a set of principles about redeploying staff, as detailed in section two. This will support workforce management processes and allow for more straightforward redeployment, rather than questions of liability needing to be answered anew each time.

Cross-organisational working and regulation

- A more proportionate, risk-based approach to regulation should be generated, built on learning from the approach taken during the pandemic. Such an approach should enable rapid decision-making at a local level, and use insight gained through other means to identify where safety risks are emerging.

Technology

- It is vital that national steer is provided on requirements for HR software, to allow trusts to procure services safe in the knowledge that if they adhere to national requirements there will be interoperability at a local level. This should come as part of wider work on digital interoperability across system working.
- Patient outcomes from virtual consultations and remote care must be evaluated as a matter of priority, with feedback incorporated into ongoing operation of these digital platforms via co-production with patients. A national approach must then be taken to identifying what good looks like in terms of the delivery of true digital services. Revenue funding should be made available, to support this through the funding of software licenses, training and educating and other new digital support services.
- Additional capital funding should be made available to enable trusts to provide staff with necessary home working equipment, to ensure that this remains a viable option for flexible working going forwards.

Making use of new roles

- The GMC's work on the regulation of MAPs should be prioritised to enable fuller use of these roles.
- Health education institutions should consider expanding trainee settings to more types of trust and should retain clinical placements for final year students. Mandatory training should also be reviewed with the objective of giving trusts greater discretion over what can be taught through on the job practical (rather than theoretical) learning.
- Development of new entry level healthcare roles should not be mandated of trusts until the backlog of care resulting from the COVID-19 outbreak is at a manageable level. Existing routes should continue to be recruited to instead. If new roles are created at a national level, it is vital to have a transparent national conversation on this to attain trust input before implementation.

Funding

- Calls for funding to specific areas of innovation as per this report's recommendations should be actioned. Of central importance is the retention and recruitment of NHS staff, which requires investment in wellbeing, improved technology, and greater flexibility in working patterns and roles. This will improve trusts' ability to deliver high quality care. Trusts are continually working to improve their offer to staff but are constricted in the range of improvements they can make without appropriate additional funding.

Your feedback is very welcome. For any comments or questions please contact sarah.white @nhsproviders.org

For more information:
www.nhsproviders.org/topics/workforce

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